ECT
PRE-TREATMENT REVIEW COMMITTEE STATEMENT

(For involuntary patients, persons under guardianship/conservatorship, voluntary patients without capacity, and voluntary patients without verification of capacity)

We, the undersigned physicians, have reviewed the treatment record of patient

_____, which included the
(Patient)

psychiatric history and examination by _____, MD, as well
(Treating Physician)

as specific statements by _____, MD, indicating
(Treating Physician)

the reasons for the choice of ECT, that all reasonable treatment modalities have been carefully considered, that convulsive treatment is definitely indicated, and that ECT is the least drastic alternative available for this patient at this time.

Based on personal examination of the patient by _____, MD,
(Consulting Physician)

and our review of the patient's treatment record, we agree with the opinion and recommendation of _____, MD, that ECT is the treatment
(Treating Physician)

of choice for the welfare of this patient.

_____ _____
(Date) (Consulting Physician – Appointed by the Facility)

_____ _____
(Date) (Consulting Physician -- Appointed by Local Mental Health Director)